

## FAX/WRITTEN REQUEST BASIC INFORMATION

PROVIDER INFORMATION		
NAME	PROVIDER'S MEDICAID NUMBER (7 digits)	
TELEPHONE NUMBER	FAX NUMBER	
CLIENT INFORMATION		
NAME	PIC NUMBER (AB-122300-SMITH-A)	
SERVICE REQUEST INFORMATION		
Description of service being requested		
PROCEDURE CODE	NUMBER OF UNITS REQUESTED	NUMBER OF UNITS USED THIS YEAR
MEDICAL INFORMATION		
Dates of injury or illness		
DIAGNOSIS CODE	DIAGNOSIS NAME	
PLACE OF SERVICE		
How will approving this request change the course of treatment?		
Goal of treatment?		
What is the clinical justification for this request (if not addressed above)?		

Please send or fax any necessary additional documentation with your request to:

Medical Assistance Administration  
 Provider Request/Client Notification Unit  
 PO Box 45506, Olympia WA 98504-5506  
 Telephone (360) 725-1584  
 Fax (360) 586-1471